**Health Care Access and Reimbursement Task Force**

**1-3:30 PM Senate Finance Committee Hearing Room, Miller Senate Office Bldg, Ste. 3E**

**January 28, 2008**

Task Force Members Present: Secretary John Colmers (Chair), Delegate Robert Costa, Senator Rob Garagiola, Dan O'Brien (for JB Howard), Senator Thomas Middleton, Delegate Joseline Pena-Melnyk, Ralph Tyler, Dr. George Bone, Dr. Joseph Fastow, Dr. Fannie Gaston-Johansson, Dr. Ivan Walks, Bill Casey (for David Wolf) Absent: T. Eloise Foster, Stuart Guterman

Staff present: Rex Cowdry, Anne Hubbard, Ben Steffen, Lydia Isaac, Linda Bartnyska

Secretary John Colmers, Chair, called to order meeting at 1:15 p.m. The Task Force approved the December meeting minutes as written.

**Physician Supply and Reimbursement Concerns—Provider and Payer Perspectives**

Dr. Thomas Lawrence, Chief Medical Officer, Peninsular Regional Medical Center, presents on Supply and Reimbursement Concerns in Rural Areas.

Dr. Lawrence presented his analysis of the Maryland physician workforce across 30 specialties, with particular focus on the Eastern Shore. He found that on the Eastern Shore 18 specialty areas were in short supply, and five more faced impending shortages. Dr. Lawrence reviewed the results of the MHA/MedCHI analysis. The statewide analysis forecasted the impact of retirements, residents remaining in State, and in-migration on the primary care physician (PCP) supply, and estimated that there will be approximately 40 primary care physicians per hundred thousand in 2015. The requirement of 8 OB/GYNs per 100,000 MD residents is barely being met statewide, and will likely continue to decline. Malpractice costs and reimbursement levels appear to be the main factors influencing OB/GYN recruitment. Medical specialists will be significantly impacted by retirements, with the Capital and Eastern regions having the highest percentage of physicians over age 60 (nearly 30%).

A Peninsula Regional Medical Center staff survey in June 2006 indicated that 35% of all practices would not take new Medicaid patients, along with 56% of PCPs, and 36% of surgical specialists. About 25% of PCPs would not take new Medicare patients, indicating a clear shortage in providers that would take all payers. The June 2006 analysis also indicated very significant wait times for a new appointment with a specialist. Some specialties, such as dermatology, had wait times as long as four months. Nineteen specialties indicated shortages and said they would recruit help if they could. The staff survey identified a need of 34 full-time additional physicians, twelve of which were PCPs. The survey asked physicians to identify succession planning needs, and it was determined that 64.8 physicians in 19 different specialties would be needed. Aggregating the current needs and the projected needs would mean a need of nearly 100 doctors across 29 specialties on the Eastern Shore. From an economic standpoint, the

98.8 needed physicians would bring an additional 829 jobs on the Eastern Shore, along with a $28,777,917 infusion into the local economy. It was also noted that in comparison to other sectors of the economy, United Health Care is doing extremely well.

*Recommendations*: Learn from what other states are doing, including looking at tort reform which worked well in Texas; Loan forgiveness programs—average debt for graduating doctor is 130K; Improvement on reimbursement—commercial reimbursement rates in comparisons to Medicare are 98% in MD compared to 116% nationally. This makes recruitment difficult.

Task force member's discussion noted that even after additional money was provided to the hospital via the Trauma Fund, they are still experiencing shortages. The additional funds were helpful and much appreciated, but issues of work environment and malpractice still make recruitment difficult. Further once staff shortages exist, the work environment continues to become more difficult as less house staff means incoming physicians face undo burdens, further hampering recruitment efforts. Some recruitment incentives are offered such as relocation expenses and signing bonuses. It was also noted that they currently have no residents, but would be very interested in establishing institutional relationships to obtain residents.

<u>Henry Miller, PhD, Navigant Consulting (contract with CareFirst) presents on Carefirst's Perspective on Provider Supply and Payment Levels in Maryland</u>

Mr. Miller presented findings based on Navigant's estimate of the number of physicians in MD, while admitting that conjuring this estimate is difficult and that projections of need are even more difficult. The Navigant study of data collected and adjusted on a consistent basis shows that physician supply in MD is well above national levels. Their findings suggested that access to care in areas of shortages should consider new approaches to providing services, and that reform in provider payment and delivery is a critical element in providing access to care. Nationally collected data ranks MD fourth highest in patient care physician to population ratio in the US. The ratio throughout the entire northeast region of the US is very high.

The Navigant study found wide differences in estimates of supply in MD between the MHA/MedChi study and their data—for instance Carefirst's claims history shows payments to approximately 16,500 physicians with office locations in MD. The MHA/MedChi model estimates that approximately 10,000 FTEs practice in MD, while the AMA and AOA data show 17,000 physicians in clinical practice. Differences may have come from ways in which the number of physicians practicing out of state were calculated, as well as the way the FTE adjustment was made. Navigant also claims that the MHA/MedChi study made unique adjustments which limited the opportunity to compare its finding to national averages and to physician supply estimates for other states. Further, one of the largest differences between the two studies was the number of physicians in the DC area, and Navigant's analyzed the number of patients who cross between areas or across the state's border when they seek care, and found that fees paid to DC physicians showed that 45% were for care of a member living in MD. More than half of the reduction in physician supply in the MHA/MedChi study is concentrated in the

National Capital area. The Navigant study also found that utilization of physician services for private payers in MD is more than 20% above national averages, which supports their assertions that the number of physicians in MD is higher than the MHA/MedCHI study would indicate.

The Navigant study also analyzed the relationship between geographic distribution of supply versus fees, and found little linkage between supply and fees. Private payer fee levels for physician services in the northeast are at the 25th percentile of relative national levels and physician supply levels are well above averages, indicating that the higher the physician supply the lower the fee levels, which is supported by the conclusions of a recent GAO study.

The areas of agreement between the two studies include many useful strategies to promote training, recruitment, and retention of physicians, including rotations of residents in regions with shortages, focus on placement of residents in rural areas, loan forgiveness programs, regional capitation of some medical school slots, increased frequency of assessment and planning, and increased focus on retention of residents in state. Alternatives supported/enabled by technology should also be considered (including telemedicine, alternative primary care models, and rotation of specialists), in addition to recruiting and training changes.

Task force members discussed the Navigant presentation and expressed a desire to know how many patients each of the 16,000 physicians saw. Multiple task force members noted that this ratio was the more important number, and Mr. Miller expressed willingness to do this analysis. It was further noted that higher utilization rates may be due to people out of state using Maryland's many academic centers. Mr. Miller admitted that shortages may exist in areas of the state, but on a statewide basis they did not find a shortage. It was also noted that telemedicine, while useful in come capacities, will not help someone in an emergency situation who needs a specialist for urgent care.

CareFirst would welcome the opportunity to sit down with MedChi to reconcile these differences. The differences may have originated with the calculation of the National Capital area, the number of doctors who serve MD patients, how federal physicians are treated, different methodologies, and differences in the accounting of clinically available physicians. There was an additional request for information on what CareFirst is doing to address areas of the state where it admits there are shortages.

**Current State/Federal Programs to Assist Communities with Work Force Shortages—Jeanette Jenkins**

The Federal government has a series of grants and programs to help with health care access at the state level. These include Federal shortage designations which serve as the entry point to qualify for federal resources, affecting workforce and other providers such as Federally Qualified Health Centers (FQHCs). These resources have a major impact on access to care for the underserved, development of community health benefits, and the local economy, as well as serving as a catalyst for community engagement.

Federal shortage designations: Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs)/Populations (MUPs). The Federal government depends on the states to recommend areas, though since the Maryland Primary Care Organization cannot survey the whole state, proposals are typically generated in response to community requests. Thus there are some areas of the state that have not been examined. Designations must be updated every four years or they expire. Criteria for designation include service area, contiguous area, travel times, provider capacity, population demographics, thresholds, and population health status. Disciplines for HPSAs usually include dental, mental health, and primary care, and fall into categories of facilities, geographic area, and populations.

Workforce programs: J-1 Visa Waiver Program (J-1), Loan Assistance Repayment Program (LARP), and National Health Service Corps (NHSC). The J-1 program allows foreign national physicians to stay in the US for 3 years after their training if they agree to provide care in shortage areas (a national interest waiver can allow them to stay for an additional two years after the J-1). J-1's are primarily primary care and mental health providers though other specialties providing direct care are allowed. There are 30 slots available each year. LARP is for US physicians who agree to provide care in shortage areas for up to 3 years in a designated HPSA area. Currently only primary care and psychiatrists are allowed. Most recently 9 awards were given out in one year. NHSC includes health professionals from a variety of disciplines, and states may request deployment of a NHSC professional, but final decisions are made by the federal government using HPSA scores. In 2007 MD had 11 NHSC physicians, which included 5 physicians.

Task Force members noted that a recent liberation of the H1B Visas program, which does not require 3 years of participation, means less doctors are applying for J-1 program, and this decline is anticipated to decline in MD as it has in the rest of the country. Further, the problem is not always a shortage of resources but an access to services problem, as is the case in Baltimore City and perhaps in the National Capital region as well. Wherever there are Medicaid or underserved populations, there will likely be a shortage, so the number of physicians alone does not provide a complete picture.

**Possible Changes to the Provider Panel Statute §15-112—Commissioner Ralph Tyler, MIA.**
The Commissioner presented the Task Force (and previously MedChi) with possible language modifications to Insurance Article §15-112 (L) based on previous Task Force discussions. The presentation was prepared to be helpful to the Task Force, and the modifications presented include language which places a greater emphasis on disclosure, a clearer definition of an HMO and non-HMO provider panel, a provision that requires the provider contract to disclose the carriers comprising each panel and all the fee schedules for the 20 most common services billed by a provider in the same specialty as the provider for each panel, and allows the provider to reject the fee schedule. Task Force members noted that penalties for transgression are not represented, as MIA does not regulate providers

**Approval of Interim Report**: Task Force members reviewed the Interim Report prepared by the staff prior to the meeting. Their comments and suggestions were incorporated into the final Interim Report which was approved.

**Sub-group development options**: Task Force members will be contacted by email to select an area in which to participate from the following list of suggested sub-group options: Market Organization Factors - Payer concentration, practice size, changes in insurance products; Costs to system - Over and undersupply of providers, impact of uncompensated care; Adoption of pay for performance reimbursement, tiered networks based on quality and efficiency, and alternatives to fee-for-service; Efficiencies- Elimination of administrative duplication, adoption of health IT, use of comparative effectiveness research

Adjournment 3:10

Next meeting will be Feb. 25, 1 PM in Annapolis in the House and Government Operations Conference Room.

Respectfully submitted,
Laurel Havas